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*On account of a misunderstanding this meeting was announced in the January, 1943 issue of the Journal as the Annual Meeting. This was an error.—Ed.

Publication in the JOURNAL OF PERIODONTOLOGY SUPPLEMENT *is not to be understood as endorsement by the journal or the* AMERICAN ACADEMY OF PERIODONTOLOGY *of opinions expressed in any article, abstract or extract. The object of publishing the various views is to present them without prejudice to the reader for his own evaluation.*

A Message from President Dement*

Dear Friends:

Much water has passed under the bridge since we met in annual convention in Houston, Texas, October, 1941, and scientific development continues at a rapid pace. It is unfortunate that we have had to be denied the privilege of meeting, and learning first hand from those who have carried on scientific investigation into the hidden secrets of forces affecting the oral cavity and in turn the general systemic condition of mankind, as well as the systemic conditions reflected in the oral tissues. Of course, we would not complain about having to call off the 1942 meeting in Boston, since we are all desirous of coöperating and doing all that we can to help win the war as soon as possible. Here's hoping that our brave boys, along with our allies, will soon have Hitler, Mussolini, Tojo and Company, knocked out and that we will be able to win a peace based on the principles of Christianity. A peace with any other foundation cannot stand.

We had an unusually fine program prepared for the Boston meeting and we regret that we could not "put it on." All the committees had worked hard and rendered a wonderful service. Too much cannot be said in regard to their efforts. I, as president, appreciate deeply their coöperation and wish to congratulate them on a task well done.

The Council and a few of the members had a very enjoyable session in St. Louis last August, when we met to transact business for the Academy. You no doubt, read the letter from Secretary Ray Johnson regarding what was accomplished at that time. A report of the St. Louis meeting also appeared in the January Journal of Periodontology. If you haven't already done so, I would suggest that you read it for the information contained therein.

We had another satisfactory meeting in Chicago on February the twenty-second. There was a good attendance—about forty—which enabled us to transact business, not only for the Council, but for the Academy as a whole. Among other matters of business several names were presented and accepted; these dentists will be invited to join the Academy. While we do not necessarily care to build up a large membership for the Academy, we are interested in knowing the men over the country who are particularly interested in periodontia and who are working earnestly in this field. Do you have men in your section who would make good Academy members? Bring them to the next meeting which we hope will take place soon.

The American Dental Association has decided to hold a skeleton meeting in Cincinnati, in October. The Academy is considering a plan to hold a regular scientific meeting just preceding the meeting of the official bodies of the A.D.A., and I am hoping that nothing will interfere with it. It is our desire to coöperate with the Office of Defense Transportation, yet we feel that we should have a meeting in order to keep up with scientific developments. Pathological conditions

*To the members of the American Academy of Periodontology, April, 1943.

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of the mouth have such an important bearing on general conditions and vice-versa, that we believe we should make every effort to keep in touch with the progress of periodontology and related sciences. I have written Mr. Eastman, who is head of the O.D.T., explaining this and asking for his sanction of our meeting. As soon as I can hear from him, (have requested an early reply), the wheels will be set in motion to build up a good program.

In case we are permitted to hold the meeting, I hope each of you will make every effort to be there. We will give you a program well worth the effort. Personally, I am a little anxious to see our family back together again.

With sincerest best wishes and regards to each of you, I am

Sincerely,

ROBERT L. DEMENT,
President

NO NINETEEN FORTY-THREE SCIENTIFIC MEETING AMERICAN ACADEMY OF PERIODONTOLOGY

THE purpose of a plan to publish Supplements to the regular issues of the Journal of Periodontology this year was to compensate the membership of the American Academy of Periodontology in a small degree for the lack of an Annual Meeting. This Supplement to the January issue was to furnish the President of the Academy an opportunity to contact the members formally and to record the reasons for the Council's decision to postpone the scientific sessions again in 1943.

However, at the Chicago business meeting and since that time there has been much confusion and uncertainty because of the secret hope that many members had for a short scientific session to be held in Cincinnati in October.

It was not until June that the final decision was reached that to arrange such a meeting this year would be inadvisable.

The following extracts from a letter sent by the President to the membership are self-explanatory. They are printed for the information of the many other dentists who attend Academy meetings:

. . . The Council [American Academy of Periodontology] and some of our members met in Chicago, February the twenty-first and twenty-second, 1943, at which time matters pertaining to the business of the Academy were discussed and acted upon. At this meeting the matter of holding a regular meeting in Cincinnati, just preceding the skeleton meeting of the A.D.A., in October, was discussed thoroughly. While it was the concensus of opinion that we should hold a meeting this year, if possible, it was thought that since we had agreed to coöperate with the Office of Defense Transportation in regard to the Boston meeting, and since the travel situation was just as acute, if not more so, this year, we should still abide by the wishes of the O.D.T.

As I have already stated, the committees did such a wonderful job last year in preparing for our meeting, I did not feel like asking them to undertake such a task again and it go for naught. So shortly after my return from the meeting in Chicago, I wrote to Mr. Joseph Eastman, of the O.D.T., and received a reply from which I quote the following: "The need for travel conservation is greater now than it was when your Association took action in cancelling its meeting last year. Military and essential business travel has increased substantially since that time and the coming months will see further increases. Consequently, although we are still operating on a voluntary basis, we are urging strongly that travel-stimulating meetings, gatherings, etc., be cancelled wherever possible. Many groups are following this suggestion and are cancelling their 1943 meetings. Others, feeling that they must have some skeletonized gathering for the sake of performing war work which is vital to the war program and to their organizations, are planning to meet. In all cases, however, we are asking that, first, meetings be cancelled and second, if this is not possible, that attendance be minimized. We hope that controls over passenger travel during the coming months will not be necessary, but frankly, we must save an increasing amount of travel voluntarily if such controls are to be avoided."

After receiving the above, not wishing to take the whole responsibility of postponing the meeting, it was sent to other members to ascertain their reactions. They all agreed that the proper thing would be to call the meeting off.

So, as much as I regret it, this is to inform the membership that the Academy of Periodontology will not hold a regular scientific meeting this year, due to the travel situation.

Sincerely yours,

ROBERT L. DEMENT,
President.

In Our Opinion

INTRODUCTION

[Copy of letter sent to Drs. Lillian Barkann, Frank F. Beube, Harold K. Box, Bernhard Gottlieb, Isador Hirschfeld, G. R. Lundquist, Balint Orban, R. W. Rule and Charles H. M. Williams.]

March 2, 1943

Dear Doctor - - - - - :

The Editor of the Journal of Periodontology has asked me to organize a section of the Journal to be devoted to controversial matters in the field of periodontology. She has suggested as a name for this section "In Our Opinion." I am to write a statement of the problem and my opinion concerning it and send this to several of those likely to have scientific or clinical evidence on it, for their reaction and opinion. These opinions, with possibly a coördinating statement in conclusion, will be published—one subject in each of the issues of the Journal each year.

I am enclosing a statement about 'Reattachment' and am asking you to be one of those to write your reaction and opinion on it. I suggest that you make your discussion briefer, if possible, than my statement so that the group of replies may not become too voluminous.

Sincerely yours,

Harold J. Leonard

REATTACHMENT

(Initial Statement)

By HAROLD J. LEONARD, D.D.S., B.A., *New York City*

Reattachment of the investing tissues of the tooth after a pocket has once formed in periodontoclasia has been a subject of controversy ever since 1894. At that time W. J. Younger stated that gingival tissues detached by pyorrhea alveolaris would again attach themselves under appropriate treatment. This finding has been the common experience of skillful periodontists ever since.* Eugene Talbot about the same time noted the epithelial lining of the pocket and stated that reattachment was not to be expected from a histological standpoint and that reduction of pocket depth when present was due to shrinkage of the gingival flap leading to recession. Talbot's position has been taken by most of the histopathologists since that time (Hartzell, Gottlieb, Orban, Kronfeld, and others) and is still held by most of them.

The truth of the matter appears to lie in the fact that the epithelial pocket lining is capable of attaching itself to tooth surface which has been rendered free of debris, providing the surrounding connective tissue binds it tightly against the tooth surface. Such epithelial reattachment obliterates the pocket without appreciable recession although it adds little to the support of the tooth. Subsequent recession of this reattached tissue appears to depend on further injury either in the form of irritating accumulations on the tooth surface against the gingival margin or on toothbrush trauma in which the keratin layer of the overlying gingival epithelium is scrubbed off.

*See "A Case of Reattachment" by Dickson G. Bell, *J. Periodont.* 8(1):30–32. Jan. 1937.

Also "A Symposium on the Etiology, Diagnosis, and Treatment of Paradental Diseases" by Robert W. Rule, Roy B. Wright, and T. Sydney Smith. *J. Calif. State D. A.* 18(4,5,6):1942 and 19(1,2): 1943. With illustrations.

The epithelial reattachment to obliterate the pocket is a real reattachment, not just a close adaptation of the epithelial lining to the tooth root. The proof of this fact lies in histopathological specimens as illustrated by Harold K. Box in his *"Studies in Periodontal Pathology"*, published in 1924, pp. 75 and 76, and by a series of photomicrographs made and shown by William Reppeto at the Better Dentistry Meeting in New York, in December 1936. Doctor Reppeto kindly gave slides of this material to several who were interested. Two of these are here reproduced. They show attachment by epithelium in a forty-four year old man who had treatment of a molar tooth which was extensively involved with periodontoclasia and was marked for removal. In places the cementum was completely removed by curettage. The photomicrographs show reattachment to the dentin as well as the cementum.

The idea that epithelium can reattach to tooth surface after it is once detached is a concept which should not be difficult to accept. Gottlieb has shown that epithelium regularly grows down along the root surface in advance of the receding line of detachment as the tooth progressively erupts during the lifetime. There is always a band of such attached epithelium at first on the enamel, later on the cementum where it takes the place formerly occupied by periodontal fibers. In other words epithelium can grow against tooth structure and attach itself to it.

Fig. 1

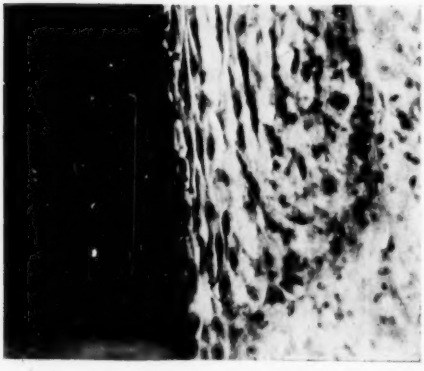

Fig. 2

It is the experience of those who resect gingival tissue to eliminate pockets that the gingiva grows up around the tooth to cover the denuded root surface to a considerable degree. If this tissue is kept in good tone by proper home care methods, the new gingival sulcus is shallow and does not reach to the depth of the line of incision. This indicates reattachment of this newly formed gingiva to the tooth surface. Since there is no evidence that such reattachment is by means of new connective tissue fibers embedded in a new layer of cementum, it must be assumed that the reattachment is that of epithelium to the old cementum.

There is reason to think that connective tissue might reattach to the cementum by means of new principal fibers embedded in a new layer of cementum provided epithelium could be kept from intervening. Beube has shown by operations deep down on the roots in which blocks of pericementum, cementum and surrounding bone have been removed that these tissues subsequently reform especially when bone powder is inserted to hasten the formation of the calcified tissues. The formation of alveolar bone as shown in radiographs in areas where pockets formerly existed and were operated upon also suggests that new pericementum may form in areas formerly involved in pockets under certain conditions. The lining epithelium of the pocket is probably the factor that interferes with such connective tissue reattachment following the usual conservative or resection periodontal operations. Histologic proof of connective tissue reattachment where pockets formerly existed is strangely lacking. It must be assumed that the obliteration of pockets without recession which commonly occurs after effectual conservative treatment is epithelial.

LILLIAN BARKANN, D.D.S.,
New York City:

Although I have known the opinions of such authorities as Gottlieb and Orban, I have always been of the belief that a definite reattachment of the gingiva to the tooth occurred after a pocket had been completely and correctly treated. The only obstacle in the way of this seemed to be an intervening layer of abnormal tissue which, if excised to the layer of connective tissue, would permit reattachment. In excising the pocket lining as much as possible of the exposed normal gingiva should be retained as a basis for regrowth as well as for the development of a wider band of tissue upon the tooth. Failure of a pocket to close completely is probably due to the inaccessibility of some bit of granulation tissue which thus remains, as a barrier, within the pocket.

I have no microscopic evidence that there is a reattachment, other than a formation of cicatricial tissue around the root. However, it would be difficult to believe that there had been no new periodontal membranes and attachments formed on teeth which had remained healthy for fifteen or twenty years after the closing of pockets. With our present facilities for histological research, this problem should be soon settled.

FRANK E. BEUBE, D.D.S.,
New York City:

Reattachment is an inadequate term as used in the literature in reference to the healing of periodontal pockets and the reconnection of the periodontal membrane to the cementum of the root. The word is inadequate because once periodontoclasia is present, that portion of the periodontal membrane which was included in the diseased area is destroyed and cannot become reattached to the root surfaces. Therefore, all questions of healing must be based on whether the various cells directly related to the teeth affected by periodontoclasia are able to form a new periodontal membrane or its like which in turn might become attached to the cementum of the root. The cementum too must be considered in the generation of a new periodontal membrane and attachment to the root.

It has been stated that maceration of the cementum is part of the syndrome of periodontoclasia, and dead cementum would not provide a base for attachment of a new periodontal membrane. This point has not been proved by those holding to this hypothesis. Even if it be true, reliance on attachment to old cementum is not essential, since if old cementum is removed and the underlying dentin exposed, a new cementum would develop, provided all other prerequisites are available.

Satisfactory proof of attachment cannot be determined by probing between the gingiva and the tooth subsequent to treatment, for the gingival tissue may only be constricted about the root. Complete evidence would have to entail the treatment of periodontoclasia, followed by histological sections of the treated teeth, and the surrounding structures, after the necessary lapse of time. The sections should show a replacement by new tissues of the previously lost periodontal membrane and bone, biologically connected to the root. This has not been demonstrated by any investigator as yet.

There is, however, evidence available from investigations at Columbia University Dental School, by the writer, on animals and from clinical cases which indicates that attachment as noted above is a probability.*

Briefly, the animal work was as follows: An incision was made over a root of a tooth, and the buccal plate, periodontal membrane, cementum and some dentin were removed. The wound edges were then sutured tightly. This area is termed the control.

A similar operation was performed on another tooth, but boiled cowbone powder was inserted into the field, and the wound edges then sutured. This was the experimental area. After four weeks the experimental area showed complete regeneration of new bone, periodontal membrane, and cementum, the cementum being attached to the old dentin. The control side even after three months showed only a fibrous healing in operated field. However, when animals were allowed to survive twenty months, the control and the experimental areas presented similar histological pictures: thick cementum (having been laid down layer by layer in a continuous pattern), a narrow periodontal membrane and trabeculated bone. Although these experiments do not simulate the conditions of periodontoclasia they do show the

* *See J. Periodont.* 7(1):16-21. Jan. 1936, for detailed report of Dr. Beube's early studies of this subject.–Ed.

ability of the cells, in the neighborhood of the operated areas, to generate new periodontal structures, which in turn become attached to the dentin.

Selected cases of periodontoclasia were then operated upon and bone powder placed into the areas where bone and periodontal membrane were lacking for two-thirds the length of the roots as shown by radiographs. Gutta percha points were placed in the pockets to demonstrate the extent of the destruction. After eleven to twelve months, in a number of cases, new bone and periodontal membrane were formed, replacing the original radiolucent areas. The radiographic findings indicated neither gutta percha points nor a fine probe could penetrate into the original pocket depths, which in some instances were 10 and 12 mm. and had now become only a 2 mm. crevice. Although the final link in the chain of evidence—a histological section of one of these cases showing attachment—is lacking, yet it is reasonable to conjecture that attachment similar to that found in animals did take place.

BERNHARD GOTTLIEB, M.D.
Dallas, Texas:

The cases referred to by Dr. Leonard where a reattachment was apparently secured as a result of curettage should be further discussed.

One has no way of knowing if the scaling was done up to the base of the pocket only or beyond it. If carried beyond it, as is sometimes done, a detachment was performed by instrumental deepening of the pocket. The place of detachment was filled with a blood clot and the instrumentally detached portion became reattached. If this occurred then the histologically demonstrated reattachments represented simply the repair of damage done during the scaling operation.

There is a theoretical possibility that Leonard's suggestion that epithelium and tooth surface will unite after removing the infected part of the tooth surface and the superficial layer of the epithelium lining the pocket. It should be emphasized, however, that this is possible only in some cases. In many instances there is no soft tissue left which is suitable for attachment.

We believe that a real attachment with new formation of cementum and attached fibres is only possible where there is bone present at the back of the pocket, having other function than that of the being the alveolar bone of the tooth concerned. After removing all pocket epithelium and infected tooth surface and leaving a stable blood clot, it might be organized into connective tissue and functional reattachment secured.

BALINT ORBAN, M.D., D.D.S.
Chicago, Illinois:

I object to the statement that Younger's claim 'detached tissue will again become reattached under appropriate treatment' "has been the common experience of skillful periodontists ever since." This would imply that whoever does not share the view of the writer is not skillful. There are, it seems to me, other much more reliable methods of determining the skill of an operator.

The statement that "the truth of the matter appears to lie in the fact that the epithelial pocket lining is capable of attaching itself to the tooth surface . . . " needs very much more scientific proof before it becomes a "truth". At this time it is only a theory—not supported by any scientific proof. The idea that epithelium can attach itself to hard substances is no proof in favor of the above theory. Epithelium attaching itself to the dentin of fractured roots has been observed by Gottlieb (1). Gottlieb also observed the epithelial attachment migrating on resorbed dentin surface (2). Epithelium becomes attached to dentin or cementum of remnants of deciduous teeth, as observed by Kotanyi (3). Epithelium can attach itself to necrotic bone sequestrums, as seen by Schonbauer (4). An epithelial attachment also forms on the surface of erupting odontomas as published by Wolf (5). An epithelial attachment will form anywhere when vital epithelium comes in contact with a hard structure. This is not a reattachment, however, but a new attachment. This is also true in Reppeto's case. It is not the old pocket epithelium which becomes attached to the scraped off root surface, but new epithelium migrates from the surface and attaches itself to the dentin. The action of the germinative layer of the epithelium is necessary to effect the attachment in these cases. The degenerated surface layer of the epithelium in the

pocket can not fulfill this function. The close adaptation of the pocket epithelium to the well-polished root surface might be clinically misleading, but it is not attachment or reattachment.

The attachment of the epithelium to the root surface is performed through minute epithelial projections into spaces in the cementum—formerly occupied by connective tissue fibers. This can not be accomplished by the pocket surface of the epithelium, but only by the proliferating epithelial cells at the end of the epithelial attachment.

I can not substantiate the claim of the writer that "the gingiva grows up around the tooth to cover the denuded root surface" after gingivectomy. I have never seen this.

Reattachment of periodontal membrane fibers to injured or resorbed dentin surface has been repeatedly observed, (6) but never in periodontal pockets. The addition of bone powder in such wounds (7) seems to hasten the process, but does not change the biologic features. This process has nothing to do with reattachment of tissue which has been detached to form a periodontal pocket.

With regard to Reppeto's case, there is no evidence that there was a pocket present previous to scaling at the area now shown. In scaling, the instrument might have been carried below the bottom of the gingival crevice and the root surface injured, and then the epithelium might have formed this attachment — but not reattachment — as there is no evidence that there was a pocket there before. The epithelium might also have been attached much farther occlusally and later migrated to the present position. The case is only an incidental finding—such as those cited before—but was not scientifically observed to guarantee the claim that it is a proof for reattachment.

REFERENCES

(1) *J.A.D.A.* 14:2178, 1927
(2) Gottlieb, Orban and Diamond—*Biology and Pathology of the Tooth*, Macmillan, 1938. Fig. 72
(3) Z. *Stomatologie*, 25:516, 1925
(4) Z. *Stomatologie*, 33:589, 1935
(5) Z. *Stomatologie*, 24:573, 1926
(6) B. Orban, *J.A.D.A.*, 15:1768, 1928
(7) F. E. Beube, *Columbia D. Rev.*, 8:1, 1936

R. W. RULE, D.D.S.
Glendale, California:

Perhaps the term "reattachment" should be changed to "biologic union" or "organic union." Some have objected to the term reattachment on the basis that it implies the same nature of attachment which existed before the pocket formation and that this has not been histologically proved. Whatever one's personal opinion about this might be, the term biologic union would seem to avoid this objection and be suitable in describing whatever *actual union* does take place, for whether the healing that occurs is an epithelial attachment or part epithelial and part fibrous connective tissue, it certainly is not a mere close adaptation of the soft tissue to the root surface.

My opinions regarding this important question have been pretty clearly stated in the *Journal of Periodontology* for July, 1938 under the subheadings "Curative Treatment" and "Healing Conditions," pp. 79 to 84. Noyes, Box, Kronfeld, Gottlieb, and other histologists have held that it is biologically or, at least, theoretically possible. Nothing about which we know in the principles of surgery would indicate that it is impossible. In numerous cases where the pathologic pockets have been very deep, a complete healing has taken place and the tissues have remained *in situ* for many years and still remain so. This fact is clinical evidence which is pretty hard to refute.

As to the histologic nature of the healing, my judgment or "opinion", based largely on clinical experience and what knowledge I have of histology and pathology, little as it may be, is that it is an epithelial union in the supra-alveolar portion of the healing but that in the deeper areas, where the inflamamatory process was active, with the presence of macroscopic pus, the new tissue formed as a result of conservative treatment is fibrous connective tissue and that if there is a matrix of bone to which these fibers may attach, the opposite ends of the fibers become imbedded in new cementum laid down over the root surface.

In six months to a year following skillful conservative treatment, roentgenographic evidence seems to show clearly that the diseased condition of the bone has been checked and the radiolucent matrix has filled in and become more dense again, or that a

healthy cortical layer of bone has formed over the once ragged and diseased margins. The presence and condition of the cortical layer may be taken as an index of the health or otherwise of bone in the area of involvment. In a clear case of horizontal atrophy under treatment, the infection may be checked, roundcell infiltration terminated and a healthy cortical layer of bone obtained. In such cases the nature of attachment of the soft tissues to cementum, if any, will undoubtedly be epithelial. In the case of vertical atrophy where there is a wall of bone remaining around the area, I do not question that fibrous union may and does take place if the treatment meets the biologic principles of surgery.

Referring to the second paragraph of your "Initial Statement", I do not believe that the mere rendering of a root surface free from debris is, in itself, sufficient to bring about a union with the soft tissues. Definite surgical principles must be followed with thoroughness.

As to the last paragraph, it does not seem *strange* to me that there is a lack of histologic proof of organic union of connective tissues following treatment of the paradental pocket. The material for proof is extremely difficult to secure, once results of treatment have been achieved. Some may become available after the death of the patients. This possibility is not being overlooked.

CHARLES H. M. WILLIAMS, D.D.S.
Toronto, Canada:

It is true that there is a very small amount of histologic evidence to support the claim that tissues which had become detached during periodontal pocket formation, can be caused to become reattached following proper treatment. This circumstance is due, in the main, to the difficulty of obtaining blocks from human jaws which are suitable for histologic study. Teeth and surrounding tissues which may justifiably be removed for sectioning because of the presence of advanced periodontal disease usually exhibit numerous extensive pockets which are the least favourable to the induction of reattachment. Under the circumstances Box and Repetto deserve credit for the histologic findings they have reported.

A large group of conscientious periodontists claim to have induced long-sustained closure of periodontal pockets, and although this evidence does not indicate whether the reduction of pocket depth is the result of reattachment or tight readaptation, it is clinically important and is not to be ignored.

It is important at this point to stress that a large percentage of operations to induce reattachment will be unsuccessful if applied to pockets of all patterns and to patients in all conditions. Reattachment is the ideal of periodontal pocket therapy but is not easily or regularly attainable. Treatment for the reduction of inflamation and infection of the pocket wall and for the reduction of mobility of the tooth should always precede the operation for the induction of reattachment. Pockets which are isolated, narrow, straight, thick-walled, and in mouths where the local and systemic factors are relatively favourable, or where these factors are amenable to successful correction, are most liable to show pocket closure by apparent reattachment following simple treatment. More extensive pockets, or where the factors controlling healing are not so favourable, may be induced to exhibit closure following repeated gentle curettement and repeated packing. In a typical result a pocket of eight millimetres was measured with a finely calibrated probe in 1935. Since treatment there has been a two millimetre apical migration of the gingival margin and there is a one millimetre crevice. Five millimetres of depth have remained closed against any attempt to insert a probe.

Many periodontists have shown radiograms demonstrating obvious or marked alveolar regeneration in treated vertical pockets. The base of these pockets is usually close to the lower (more apical) level of the slanting alveolar edge and the gingival margin is usually prevented from moving apically sufficiently to eliminate the pocket by atrophy of the pocket wall, because it is supported by the upper (more coronal) level of the alveolar edge. The long-sustained closure of such pockets is obviously not the result of atrophy of the pocket wall. Whether the closure of these pockets is through reattachment by epithelium or connective tissue or by tight readaption is essentially an academic question, the further debate of which requires more histologic material showing the results of treatment

on carefully selected pockets. The several methods which have been clinically successful in the induction of apparent reattachment should continue to be employed in any rational and inclusive plan of periodontal pocket therapy.

The foregoing statements have been submitted to Dr. Harold Box and he is in agreement with the views expressed.

See Illustrations in my paper on "Rationalization of Periodontal Pocket Therapy" in *Journal of Periodontology*, July, 1943

Concluding Statement

HAROLD J. LEONARD:

Dr. Balint Orban objects to a part of the wording of the "Initial Statement." The word "skillful" in the first paragraph suggests to him that those who have not observed and are skeptical of reattachment are not skillful enough to obtain it. *Such an implication was not intended.*

Dr. Orban also took exception to the wording in the second paragraph, "the truth of the matter appears to be," since no convincing evidence to a histo-pathologist has been presented in this discussion or elsewhere.

He is of the opinion that basal epithelial cells can attach themselves, but that there is no histological evidence that mature surface layer epithelial cells such as would ordinarily lie against the cementum after conservative treatment, are capable of doing so. Where epithelial reattachment actually occurs it is by reason of ulcerated areas coming in contact with the cementum so that basal cells budding out to cover the ulcerated area come directly in contact with the cementum. He has a photomicrograph showing such an area.

Dr. Orban points out that a part of the root surface formerly involved in the pocket in both Box's photomicrographs (Figs. 99, 199, and 101, *Studies in Periodontal Pathology, 1924*) and Reppeto's No. 2 is now covered with what is apparently reattached or at least adherent white fibrous connective tissue with fibers running parallel to the root surface and none imbedded, as there is no new cementum to be seen. This is a type of reattachment which has previously not been discussed.

The proof of reattachment of new periodontal membrane with new cementum as discussed by Beube or of attachment by the surface layer cells of the epithelial lining as suggested in the initial statement is apparently yet to be obtained and every periodontist interested in this subject can attempt the experiment to obtain it by the following method:

Select a tooth with an advanced periodontal pocket which must be extracted for reasons of esthetics or for prosthetic convenience, but which could be saved from a periodontal standpoint. With a disk cut a groove horizontally across the tooth sufficiently deep to mark the dentin. Measure the distance from this groove to the bottom of the pocket accurately. If possible make a radiographic record also with gutta percha points reaching to the pocket depth. Treat the pocket and get clinical reattachment and then in the course of a few weeks* remove the tooth in a block of tissue deep enough to include the former pocket area. Put the block in a bottle of 10% formalin and send to a histopathologist for preparation of sections and slides.

It is high time that the science of periodontology had some facts in this field on which to base scientific clinical practice.

April 1, 1943

* See Beube's experiments, p. 7, which show the importance of time (20 months) "to generate new periodontal structurer" other than a "fibrous healing."

Converging Pressure

By ROWE SMITH, D.D.S., *Texarkana, Ark.-Tex.*

THERE is a natural shift of the teeth toward the median line of the face and in some mouths this shift appears to become accelerated which causes a bunching, etc., of the lower anterior teeth. The reason why it is more pronounced in the lower anterior area than in the upper is probably because of a difference in the growth and development of the lower jaw to that of the upper jaw.

In conditions where the lower anterior teeth are crowded or pushed into an abnormal position due to converging right and left lateral pressure from cuspid to cuspid, often the lower incisor teeth are forced into supraocclusion or lingual occlusion, which is the only ways these teeth can go. Even though the occlusal pressure is relieved this force will be continuous and often will eventually exfoliate one or more of these teeth. Many people do not seem to have enough space between the right and left lower cuspids to accommodate the four incisor teeth. When the incisor teeth are bunched or crowded badly it is very difficult to maintain good oral hygiene which is necessary for periodontal health.

For adults, removal of the most seriously affected one of these teeth will materially aid in relieving this condition and the space will close naturally, or with the use of very simple ligatures.

Often the space created by the necessary removal of a lower incisor on account of apical or periodontal infection can be closed very easily by utilizing the seemingly ever constant right and left converging pressure without having to construct a fixed or removable incisor replacement.

Reduction of the right and left converging pressure from lower cuspid to cuspid will allow the remaining lower teeth to assume a more natural position and will also reduce the *buckling* pressure throughout the entire upper and lower dentition. This procedure in conjunction with other required periodontal treatment will help to control periodontal disease.

405 East 5th Street

THE JOURNAL OF PERIODONTOLOGY

Vol. 14, 1943

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Devoted to furthering knowledge and appreciation of periodontology. Abstracts of periodontal literature, beginning 1927, to be published continuously.

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Organized May, 1914

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All scientific sessions open to members of the American Dental Association

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St. Paul, Minnesota

Postgraduate Lecture Program for

THE AMERICAN ACADEMY OF PERIODONTOLOGY

April 26, 27, and 28, 1943

Sponsored by

THE W K. KELLOGG FOUNDATION INSTITUTE

GRADUATE AND POSTGRADUATE DENTISTRY

University of Michigan, Ann Arbor, Michigan

All lectures were held in Kellogg Foundation Institute

MONDAY, APRIL 26

9:00-10:00

Registration: 3000 Kellogg.

10:00-10:30

Orientation and Announcements: Committee on Arrangements.

10:30-12:00

Lecture: Moniliasis. Lt. Col. Arthur R. Woodburne, M. D., Fitzsimmons General Hospital, U. S. Army, Denver, Colorado.

12:15

Luncheon: Michigan League. Dean Russell W. Bunting and Col. Woodburne, Speakers.

2:00-3:15

Lecture: Fungus Activity and It's Management in the Oral Cavity; T. A. Hardgrove, D.D.S., Fond du Lac, Wisconsin.

3:30-5:00

Lecture: Moniliasis. Continued by Col. Woodburne.

7:30-9:00

Lecture: Fungus Activity and It's Management in the Oral Cavity; Continued by Dr. Hardgrove.

TUESDAY, APRIL 27

9:00-10:15

Lecture: Obesity: Cause and Management. L. H. Newburgh, M. D., Professor of Clinical Investigation in the Department of Internal Medicine, University of Michigan; Member of the Committee on Aviation Medicine of the National Research Council; Chief Visiting Fellow of the Naval Medical Research Institute, Bethesda, Maryland.

10:30-12:00

Lecture: Adequate Diet in War Time. Dr. L. H. Newburgh.

12:15

Luncheon: Michigan League. Informal discussion period pertaining to diet. Comments by Dr. Phillip Jay.

2:00-3:15

Lecture: Blood Chemistry. Howard B. Lewis, PhD., Professor of Biological Chemistry, University of Michigan.

3:15-3:30

Intermission.

3:30-5:00

Lecture: Blood Chemistry (Continued). Professor H. B. Lewis.

6:30

Dinner: Michigan League. Speakers: Mental Hygiene in War Time, Dr. William S. Sadler, Chicago, Consulting Psychiatrist of Columbus Hospital; Consultant in Psychiatry of the W. K. Kellogg Foundation.

The Dentition of the Eskimos of Canada's Eastern Arctic (with colored movies and models), Charles H. M. Williams, D.D.S., Toronto, Canada.

WEDNESDAY, APRIL 28

9:00-10:15

Lecture: Psychiatry and the War, Dr. William S. Sadler.

10:30-12:00

Patient Demonstration: Various Systemic Disturbances and Oral Lesions, University Hospital. A. C. Curtis, M.D., Professor of Dermatology and Syphilology. School of Medicine, University of Michigan.

12:15

Luncheon: Michigan League. Informal Discussion of Plans for a 1944 P. G. Lecture Course.

2:00-3:30

Lecture: The Anemias. Cyrus C. Sturgis, M.D., Professor of Internal Medicine; Chairman of the Department of Internal Medicine; Director of the Simpson Memorial Institute, University of Michigan.

ACADEMY MEMBERS WHO ATTENDED LECTURE COURSE:

Aiguier, James E.
Ball, Edward L.
Brunk, Walter C.
Buck, Charles H.
Cottrell, Ivan R.
DeRose, Michael
Drake, Marion L.
Hard, Dorothy G.
Huntington, Roger E.
Jones, Martha Erma
Leonard, Harold J.
Loftus, J. Leo
Rich, Celia
Romine, E. Romle
Spalding, Grace Rogers
Wescott, R. L.
Williams, Chas. H. M.
Yeretsky, Willa

SECRETARY'S REPORT
SPECIAL BUSINESS MEETING A. A. P.
FEBRUARY 22, 1943

The following is a report of the Special Business Meeting of the American Academy of Periodontology held Monday, February 22nd, 1943, in the Medical Arts Building, 185 North Wabash Avenue, Chicago.

The meeting was called to order by President Robert L. Dement with the following members present: Hunter S. Allen, Edward L. Ball, T. E. Braly, Clarke E. Chamberlain, Robert L Dement, Lynn A. Fonner, Bernard D. Friedman, J. D. Hertz, Isador Hirschfeld, Roger E. Huntington, J. A. Jacobsmeyer, Austin F. James, Raymond E. Johnson, Olin Kirkland, Harold J. Leonard, Virgil Loeb, C. Wesley Marriott, Arthur H. Merritt, Gerald A. Mitchell, Don F Mosher, Balint Orban, Samuel R. Parks, Celia Rich, E. Romle Romine, Carlos Schott, James A. Sinclair, Rowe Smith, Grace Rogers Spalding, Justin D. Towner, Joseph R. Walsh, R. L. Wescott, and Willa Yeretsky.

The minutes of the previous meeting were read and accepted.

The Treasurer's report in the form of the annual audit was read and accepted.

The report of the American Board of Periodontology, H. J. Leonard, Chairman, was accepted as read. It was moved and carried that all members of the Board hold over the same as the officers of the Academy until the next general meeting is held.

The following paragraph of a letter to the Secretary from one of our members was read:

"At this time I would like to tell you that I have set aside $10,000 in my will for the American Academy of Periodontology to be used for research in connection with periodontal disease in any way that the officers of the American Academy of Periodontology may see fit. Also, I have made a provision that the American Academy of Periodontology can designate any recognized dental college for use of this fund under the supervision of the Academy. I hope that maybe more of us can do something along this line and possibly many others much more. I believe that this is one of the prime needs of periodontia today. We must in some way obtain a sufficient amount of money to carry on research which will give us more definite information as to the etiology of the various types of periodontal disease."

A sincere vote of thanks was extended to this member by the Academy, whose generous gesture was loudly applauded.

Letters from Dr. Dickson G. Bell and Capt. Earl Gilmore were read regarding a newly created periodontia section in the U. S. Army. It was moved and carried that the Secretary write Col. Bennett. It was also moved and carried that a resolution be drawn up to be sent to the Surgeon General's Office of the Dental Corps calling attention to the importance of the gingival tissues in maintaining the health and fitness of the American soldier, and recommending that similar sections be established as a routine procedure in the Dental Corps. It was suggested by the Council that this resolution be drafted by Drs. Sinclair and Towner.

Dr. Edward L. Ball extended an invitation to the Academy to hold its annual meeting in Cincinnati at the time of the A.D.A. business meeting.

It was moved and carried that the twenty-seven applicants whose names were read (having been approved by the Council and considered by the membership) should receive invitations to become members.

Letters from Mrs. W. Y. Hayden and Mrs. Andrew J. McDonagh were read by the Secretary.

It was moved and carried unanimously that eight associate members, named and recommended by the Council, be invited to become active members.

It was moved and seconded that the scientific meeting be called off this year. Dr. Coolidge suggested that a skeleton meeting of three or four good papers be held thus keeping up the interest of the members. Drs. Merritt, Kirkland, and Smith expressed themselves as being in favor of such a plan. After some further discussion the motion was withdrawn, and it was moved and carried that the Council consider the advisability of holding a regular two day meeting in Cincinnati.

The meeting was recessed for lunch.

Dr. Edgar Coolidge had made arrangements at the Top of the Town Restaurant for a luncheon, where over thirty sat down to lunch together. While we all enjoyed this social get together, too many faces were missing, to our keen regret.

A motion was made by Dr. Celia Rich that a letter be written to the publishers of *Good Housekeeping* magazine protesting misleading statements made in an article which appeared in the February issue and expressing the hope that they will take steps to retract such statements in the interest of public health.

It was moved and carried that the changes in the Constitution and By-Laws be passed on as read with the exception of changing the word "he" to "the editor" as it appears in Article III Section 6.

Dr. Grace Rogers Spalding presented an informal report on the Post-Graduate Seminar arranged for April 26, 27, and 28, 1943, at the W. K. Kellogg Foundation Institute, Ann Arbor, Michigan.

It was moved and carried that the Academy express its thanks to Dr. Coolidge for his kindness in making the necessary arrangements for the Chicago meeting.

The meeting was adjourned.

President Dement was directed by the Council to write Mr. Joseph Eastman, Office of Defense Transportation, as to the advisability of the Academy holding a Scientific Meeting in Cincinnati in October.

Let us all make plans now to attend this meeting if held. Eddie Ball assures us a very fine time in Cincinnati.

NEW MEMBERS—1943

Alfred J. Peetz, 122 East Johnson, Madison, Wis. Marquette University, 1919.
Bernhardt Frederick Schwartz, 1020 Stuart Bldg., Lincoln, Neb. Northwestern University, 1904.
Edwin O. Carter, 6305 Yucca Street, Hollywood, California.
Sam Elrod Mills, 1620 Medical Arts Bldg., Houston, Texas. Texas Dental College, 1923.
John Charles Kouns, First Nat'l Bank Bldg., Lexington, Kentucky. Atlanta Southern Dental College, 1937.
Reuben N. Albinson, 1600 West Lake St., Minneapolis, Minn. University of Minnesota, 1921.
Charles H. Buck, 602 Home Mutual Bldg., Dayton, Ohio. Ohio State University, 1923.
Marion L. Drake, 1320 B. F. Keith Bldg., Cleveland, Ohio. University of Michigan, 1915.
John M. Burbank, 2917 Chesapeake Ave., Hampton, Va. Medical College of Virginia, 1926.
Virgil Stanley Hart, 2nd and Franklin Streets, Richmond, Va. Medical College of Virginia, 1932.
Wallace Chas. Mayo, 503 South 18th St., Wilmington, N. C. Atlanta Southern Dental College, 1937.
Arthur Ward Lufkin, 6253 Hollywood Bldv., Los Angeles, Cal. University of Southern California, 1915.
Felix S. Tittle, 1011 Lake, Oak Park, Illinois. Northwestern University, 1923.
James Craig Westbrook, 1416 Comer Bldg., Birmingham, Ala. Atlanta Southern Dental College, 1932.
Thomas Edward Prosser, 542 North 18th Street, East St. Louis, Illinois. St. Louis University, 1916.
Allen Nathan Arvins, 57 West 57th Street, New York City. N. Y. University College of Dentistry, 1936.
Abraham G. Rothwein, 823 East 173rd St., New York City. N. Y. University College of Dentistry, 1933.
William M. Greenhut, 124 East 84th St., New York City. N. Y. University College of Dentistry, 1932.
Frederick H. Borst, 406 Nat'l Bk. of S. D. Bldg., Sioux Falls, S. D. Creighton University, 1907.
Abram Cohen, 269 South 19th Street, Philadelphia, Pa. University of Pennsylvania, 1923.
Lawrence A. Donahue, 1128 National Bank Bldg., Omaha, Nebraska. Creighton University, 1916.
Charles A. Wall, 1235 Castro, San Francisco, Calif.

Respectfully submitted,

RAYMOND E. JOHNSON
Secretary

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THE JOURNAL OF PERIODONTOLOGY

SUPPLEMENT TO THE JULY, 1943, ISSUE

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Publication in the JOURNAL OF PERIODONTOLOGY SUPPLEMENT *is not to be understood as endorsement by the Journal or the* AMERICAN ACADEMY OF PERIODONTOLOGY *of opinions expressed in any article abstract or extract. The object of publishing the various views is to present them without prejudice to the reader for his own evaluation.*

In Our Opinion

WHAT IS A PERIODONTIST?

Initial Statement

HAROLD J. LEONARD, D.D.S., B.A., *New York City*

A wide diversity of opinion seems to exist as to the scope of periodontia and the essential qualifications of the periodontist. It is important that a fair degree of unanimity of opinion prevails on these subjects in the Academy especially at this time when standards are being established by the American Board of Periodontology. To some, the periodontist is one who is expert in root surface treatment and in instruction in home care. To others he is an expert in the surgical resection of diseased gingival tissues. Others would add a sound knowledge of nutrition and still others would make the qualifications much broader.

As a means of arriving at common agreement, the leader of this department is stating his opinion of the desirable qualifications and work of the periodontist and submitting it to the following Academy members for criticism and comment:

Edward L. Ball	Olin Kirkland
A. W. Bryan	Gottfred R. Lundquist
Chris J. Caraballo	Harry Lyons
M. Harry Garvin	C. W. Marriott
Clayton H. Gracey	Justin D. Towner

Willa Yeretsky

A periodontist should be a dentist of wide skill and experience in general dentistry who, by extensive study, postgraduate instruction, and experience, has become proficient in the understanding, the treatment, and the prevention of gingival and periodontal disease. He should be:

1. An expert in the removal of subgingival irritants and an excellent teacher of personal oral hygiene.

2. He should be proficient in the surgical resection of gingival flaps and the surgical treatment of periodontal abscesses.

3. He should have a knowledge of the relation of occlusal defects to periodontal disease such that he knows how to correct them by reshaping occlusal surfaces, inserting bridges, making inlays for support, designing partial dentures, moving teeth by orthodontics, to the end that teeth may be stabilized and no longer permitted to shift or develop traumatic effects on the periodontal structures. While the periodontist may not himself execute the technical procedures involved in this work, he must have sufficient knowledge and experience so that his advice will be sought by the dentist who does do it.

4. He must be learned in the physiology, pathology, and bacteriology of the mouth and teeth and especially of the gingival and periodontal structures. This includes the physiology of the blood vessels and alveolar bone.

5. He should have a profound knowledge of the relationships of systemic states to gingival and periodontal disease—nutritional deficiency conditions, endocrine disbalances, specific drug effects and various nervous, blood, and debilitating diseases which have a specific or general bad effect on periodontal tissues.

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6. He should have a better than average knowledge of soft tissue lesions of the mouth.

7. He should be a good oral diagnostician, that is, competent in making a systematic oral examination which will disclose all present and potential dental and oral defects, and in planning treatment adequate to place and maintain the mouth and teeth in health, so far as present knowledge makes this possible.

There is little excuse for patients under the care of periodontists, losing teeth after the initial treatment except teeth known to be doubtful in the beginning or cases in which a subsequent complicating disease like diabetes changes the picture. By adequate examination, treatment planning, and expert treatment, teeth that are savable should be put in health and so maintained. Treatments and examinations at suitable intervals should prevent further periodontal disease, and other diseases such as caries which are at present not entirely preventable should be detected in their incipiency and treated. There should be practically complete prevention of the tooth losses which are at present the too common fate of many who believe they are having all necessary dental care. And certainly the mouth should be kept free of disease which might affect the general health.

EDWARD L. BALL, D.D.S.,

Cincinnati, Ohio

I have examined with some care the "Initial Statement" written by Dr. Harold J. Leonard, on, "What is a Periodontist?". I certainly agree with all he has to say in his introduction to the discussion which is conclusive and convincing.

His qualifications of a periodontist are well selected.

I found out a long time ago, that the removal of subgingival irritants, especially subgingival calculus of long standing was a most difficult technical procedure, even when exposed, i. e. after gingivectomy. The reader is advised to read, if he has not already done so, Bodecker's article, "The Difficulty of Completely Removing Subgingival Calculus" in the May, 1943 issue of the *Journal of the American Dental Association.*

In paragraph 1 (listing the periodontist's qualifications), is mentioned also another difficult procedure—the teaching of oral hygiene. Unless we are excellent teachers who possess patience, understanding, and determination, we shall never succeed in our struggle to establish the absolute necessity of personal oral hygiene. It is important to emphasize and to teach home treatment at the patient's every visit. Unless we stress the definite technique of daily and meticulous home care, it is useless to plan treatment, to consider operation, and to replace lost parts.

I tell my patients toothbrushing and inter-proximal massage are daily treatments.

I would like to enlarge paragraph 7, which states that the periodontist "should be a good oral diagnostician." With a more thorough and complete radiodontic service there must inevitably follow *better* radiodontic service and surely more accurate diagnosis. Clinical examination plus complete radiodontic service spell "Oral Diagnosis." I should include, too, a complete medical and dental history in this diagnosis.

As to the last paragraph I cannot close without sounding a note of warning to those dentists who promise too much to a patient, who treat cases that are too far advanced wherein prognosis is unfavorable, and wherein the health of the patient is endangered.

Congratulations Dr. Leonard on your opinion, "What is a Periodontist?" I sincerely hope that the day will come when I shall succeed in meeting and qualifying in all the merits expounded in your conception of what makes a good periodontist.

I wish also, to commend our editor for her effort in promoting the new department of the Journal, "In Our Opinion." Undoubtedly this will prove highly interesting, and indispensable in its educational value.

A. W. BRYAN, D.D.S.,
Iowa City, Iowa

I have read the "Initial Statement" expressing Dr. Leonard's opinion on "What is a Periodontist" and am quite in agreement with it. Even though I had time to participate in the discussion I could find little to say except in the way of approval.

C. J. CARABALLO, D.D.S.,
Tampa, Florida

I consider that you have completely answered the question: "What is a Periodontist?"

Your emphasis of the many qualifications to be desired and procedures to be followed in treatment and after-treatment thoroughly "black out" the superficial "one idea" periodontist.

M. H. GARVIN, D.D.S.,
Winnipeg, Manitoba

The statements you have made as to what qualifications should be held by the periodontist seem to me to be not far from perfect, consequently it becomes difficult to add to or subtract from them.

However, there is one statement which seems open to question: namely, "While the periodontist may not himself do the technical procedures involved in this work, he must have knowledge and experience to direct others," which seems to indicate that in some instances, at least, it is quite satisfactory for the periodontist to insert bridges, make inlays, et cetera. From the standpoint of the ideal it appears to me that so-called "Operative and Prosthetic Dentistry" should be divorced entirely from the practice of periodontia, admitting of course that the periodontist must be in a position to direct the construction of any and all appliances.

The biological aspect of dentistry is coming to the front, and since the periodontist, in particular, emphasizes this side of our profession, as his knowledge of the function of the dental organ is enhanced, as his study of dental physiology is intensified, as his appreciation of the meaning of departure from the normal becomes more profound, he will be in the ideal position to reach his goal.

When a periodontist has approached this goal, when he can diagnose a serious systemic state from the color and texture of the lips and mouth tissues, when he can discriminate between various vitamin deficiencies and other nutritional upsets from the mouth picture which is presented to him, I wonder if the term "Periodontist" is then the ideal title for one practicing in such a field.

CLAYTON H. GRACEY, D.D.S.,
Birmingham, Michigan

Your initial statement on the question "What is a Periodontist?" presents a thoughtful, inspiring resumé of the qualifications of such a specialist. It includes every activity and interest with which such a dentist should be experienced and conversant.

Many periodontists should be much concerned to learn, through the composite picture portrayed in these seven basic qualifications, what is expected of them as specialists in periodontia.

The statement is made in the introductory paragraph that there seems to exist a wide diversity of opinion as to the scope of periodontia and the essential qualifications of the periodontist. My interpretation of this paragraph is that to some dentists the periodontist is one who is expert *only* in root surface treatment and instruction in home care and to others he is an expert *only* in the surgical resection of diseased gingival tissue.

I do not think that such distinctions are made but that most dentists are unanimous in their conception of these matters. The difficulty lies not in a lack of uniformity of these conceptions but in their width and breadth.

They recognize for instance that one periodontist might be an expert in the surgical eradication of diseased gingival tissue and so apply himself to win renown but that he might also be proficient in the technique of root curettage and allied procedures, acquiring equal success by this method where indicated.

Another periodontist might seldom, if ever, use the more radical surgical treatment, confining his efforts to conservative methods and still be considered a thorough, conscientious operator.

But they are all accepted as periodontists, all arriving at the same goal—restoring

health to the supporting tissues of the teeth. It is quite evident that because of periodontia's completely biologic environment, clinical experience in this field, more than in others, must dictate which of several treatment techniques might prove more effective with each individual dentist. It is acknowledged that success is attainable through different methods.

In the concluding paragraph (modified), the second last sentence, the wording seems ambiguous. Couldn't it read "the too common fate of even those who do have dental care"?

OLIN KIRKLAND, D.D.S.,
Montgomery, Alabama

1. A specialist is one who devotes his time, efforts, and thoughts to one particular phase of endeavor that is connected with the profession in which he has chosen to specialize.

Before he can gain recognition as a specialist, however, he must learn a great deal about each phase of practice carried on in his profession. Furthermore, he must, through intensive study and clinical experience, acquire superior knowledge and skill in the prevention and cure of the group of diseases included within his sphere of specialization.

2. A competent periodontist is a specialist in the profession of dentistry, but before he may win such recognition, he must acquire a substantial knowledge of the fundamentals in all phases of dental practice. In addition to his knowledge of dentistry as a whole, he must acquire special knowledge of the supporting structures of the teeth. He must also familiarize himself with the pathological changes to which these tissues are susceptible, and become master of an operative technique which will enable him to eradicate the causes of the disease, and in as far as possible, prevent their recurrence.

3. After a careful study of Doctor Leonard's comments, and his seven point discussion of the subject, "What is a Periodontist?" I am in full agreement with his views.

It is my opinion that he has clearly outlined the essential requirements of knowledge and training for the making of a successful periodontist. If these seven points are mastered by one who desires to become a periodontist, there can be little doubt of his fitness to carry on a successful practice in this specialized field of dentistry, and he is entitled to both recognition, and certification as an acknowledgment of his skill and ability.

GOTTFRED R. LUNDQUIST, D.D.S.
Chicago, Illinois

I believe your statement describing what a periodontist should be covers the ground adequately. I should, however, change the arrangement of qualifications in your first paragraph of essential attainments of a periodontist. I believe it would be better to have the periodontist be first and foremost an excellent teacher of personal oral hygiene.

Unless such an approach is made first, the breakdown of proteins with their toxic irritation of the adjoining gingival tissue, is only managed when the expert removal of subgingival irritants is in order. Hence, prevention, as such, only enters secondarily.

I think the sequence might be improved by following the above with paragraphs 4, 5, 6, 7, 3, followed by the portion of paragraph one dealing with the expert removal of subgingival irritants. This to be followed by paragraph two.

HARRY LYONS, D.D.S.,
Richmond, Virginia

The Nomenclature Committee of the American Dental Association, of which I am chairman, defined a periodontist as one who is learned in the science of periodontology and skilled in the treatment of periodontal diseases. Periodontology is defined as the science and study of the periodontium and periodontal diseases. (Report of Nomenclature Committee, *J.A.D.A.*, 30 (13):1112-1114. July, 1943.) To my way of thinking, that is as far as the definition of a periodontist should be carried. To attempt to define a periodontist further is as impractical as an effort to describe a portrait. Neither can be complete or fully adequate. The greater the details in such an attempt the greater are the opportunities for debate and controversy; also, the more glaring are the omitted details.

For instance, I contend and I think I can successfully demonstrate that your statement number two is not a valid one. It is *not* necessary that one be ". . . proficient in the surgical resection of gingival flaps . . ."

to be a good periodontist. On the other hand, those who practice gingivectomy need not be ". . . expert in the removal of subgingival irritants . . ." as suggested in your statement number one.

Every attempt to expand the definition of a periodontist beyond that suggested by the A.D.A. Nomenclature Committee is open to such debate. I am sorry and hesitant to include your initial statement in this category, but I feel impelled to do so.

C. W. MARRIOTT, D.D.S.,
Cleveland, Ohio

The "Initial Statement" on "What is a Periodontist" is complete and in my opinion covers the subject adequately.

JUSTIN D. TOWNER, D.D.S.,
Memphis, Tennessee

A periodontist is essentially one well experienced in general dentistry, including periodontia, plus a sufficient knowledge of medical fundamentals to support intelligent diagnosis and treatment.

Since the seat of periodontal disease is within the alveolo-dental ligament, which is highly susceptible to local and systemic influences, the efficient periodontist must be both a dentist and mouth physician; one well versed in technical and biologic science. His judgment and skill is of supreme importance to oral health and physical welfare, combining, as it does, all phases of dental practice with that of the practical internist.

The successful periodontist is one who bases prognosis, treatment planning, and case management upon individual tissue conditions, coöperation of patient, and professional service, employing prudent methods of disease prevention, its elimination, and competent instruction in personal mouth care.

WILLA YERETSKY, D.D.S.,
Grand Rapids, Michigan

I am in complete agreement with the "Initial Statement" of Dr. Leonard as to the qualifications of a periodontist.

I would go further, however, and have the periodontist a sort of missionary to the dental profession. He should, by constant precept and reiteration, teach dentists how the supporting structures of the teeth may be kept healthy.

The periodontist should also be the liaison officer between the medical and dental professions.

Concluding Statement

HAROLD J. LEONARD

It is a little surprising to have the discussions of this subject in so little disagreement with the initial statement. In effect this means insofar as these periodontists are representative, that it is agreed that periodontists should have the qualifications set forth if they are to be considered as periodontists. In other words, the American Board of Periodontology would only be following accepted standards if it required candidates to meet these qualifications for the certification of candidates as expert in the practice of periodontia.

Doctor Lyons dissents by asserting that a periodontist may be expert without being proficient in gingivectomy or he may be expert in the gingivectomy method of treatment without necessarily being skilled in the removal of subgingival irritants. He also dissented from the wording of the last paragraph as it was first presented to him. This paragraph was therefore reworded in an attempt to meet his objections which were valid.

Doctor Garvin thinks that the "so-called operative and prosthetic dentistry should be divorced entirely from the practice of periodontia, admitting of course that the periodontist must be in a position to direct the construction of any and all appliances." This sentence would appear to epitomize the difficulties faced in the attempt to separate periodontia into a water-tight specialty. For how long can a dentist who is not himself practicing operative and prosthetic dentistry remember the details and difficulties faced in these fields sufficiently "to direct the construction of any and all appliances"? The prosthetist sees the problems presented so differently from the periodontist that collaboration is difficult and the prosthetist is often little inclined to follow the direction of the periodontist who has long been out of general practice. Unfortunately many accepted prosthetic procedures lead to periodontal difficulties. The separation of these specialties would not seem to be in the best interests of the dental welfare.

This leads one to wonder whether the attempt to make periodontia a specialty in the sense of limited practice is not a mistake from the standpoint of public service. Is not the ideal periodontist rather one who practices general dentistry with high skill and in addition has made himself expert in the knowledge of periodontology and the procedures of periodontia practice? In other words is not the ideal periodontist a dentist plus and not a dentist limited? This is a grave question which needs further debate as it involves much in the future growth of the profession as well as legal matters relating to dental specialties.

REATTACHMENT

*Case Report**

By R. W. RULE, *Glendale, California*

May 14, 1935 **March 30, 1938** **June 21, 1940**

Case History—Dental

Mrs. C., Age 45 yrs. in 1935. American. Housewife. Pain in region of lower right cuspid. Patient had formed habit of pressing pus from this area. Patient assigned to student for general paradental treatment with instruction to avoid lower right cuspid region. This area was treated by Dr. Roy Wright. Roentgenogram gave evidence of demineralized bone matrix in resorbed area mesial to this tooth. Moderate resorption elsewhere. Prior to instrumentation, this area was independently measured by Dean Fleming, R. W. Rule and Roy Wright and measurements recorded. These measurements agreed within about one mm. The greatest depth was 14 mm. at mesiolingual angle.

Subgingival curettage was undertaken by Dr. Wright, reducing the pocket depth to 6 mm. The unhealed portion was again curetted. Since then the case has been examined at intervals by several members of the faculty and at no time has the pocket depth been found to be greater than 3 mm. although somewhat skeptical examiners have produced considerable pain and hemorrhage in an attempt to go deeper.

It is interesting to note that there appears to be a fairly large sized but thin layer of calculus remaining on the root surface well within the healed area.

This case is one of many which seems to show that vertical atrophies are potential areas for bone remineralization when conservative treatment is properly employed.

* This material arrived too late to be published in the April issue (Supplement to the January, 1943 number) containing the discussion on "Reattachment" in which Dr. Rule took part. It is thought to be of sufficient interest to justify its publication here, as it properly belongs in this "In Our Opinion" department of the Journal.

Notes on the 1943 A.A.P. Postgraduate Lecture Course

By WILLA YERETSKY, D.D.S., *Grand Rapids, Michigan*

The Postgraduate Lecture Program for the American Academy of Periodontology was published in the *Journal of Periodontology* Supplement to the January, 1943 issue. Herewith, are submitted notes on these lectures in the order in which they were given.

On Monday, April 26, 1943, Lt. Col. Arthur R. Woodburne, U.S.M.C., gave two lectures on "Moniliasis". These will be published in the January, 1944 issue of this Journal.

Dr. T. A. Hardgrove also gave a very interesting discussion on "Moniliasis." However, since a complete article written by Dr. Hardgrove on this subject was published in the *Journal of Periodontology* for January, 1943, his views will not be repeated here.

On Tuesday, April 27th, Dr. L. H. Newburgh gave two lectures, one on "Obesity," the other on "Adequate Diet in War Time."

Dr. Newburgh attempted to explode the popular conceptions of obesity caused by an endocrine disorder of the pituitary; of the thyroid; of inherited tendencies. In short, he declared that obesity is due entirely to a too large intake of food.

We quote Dr. Newburgh (with Margaret W. Johnston) from *Medical Clinics of North America,* 27(2): 327-347, March, 1943:

FOOD HABITS

In the ideal state, the living organism is directed by hunger to secure food in amounts sufficient to replenish the bodily materials that have been destroyed by oxidation or have been excreted. This primitive mechanism does not give rise to sensations which are primarily pleasurable. It is, so to speak, more business-like than that. With the passage of time, hunger has come to be so closely associated with other feelings called *appetite* that the mind of man no longer distinguishes clearly between the two. Appetite, strictly speaking, is a sensation produced by happy memories. The desire for food may be the expression of real hunger, but it is more generally a response to habit or the anticipation of pleasure. It is modulated by the emotions to a striking degree. Fright, fear, sorrow, illness, displeasing sights and smells depress or even abolish it. It is stimulated by foods that give off pleasant odors, that please the eye and the palate. Happy recollections and good companionship are conducive to overeating. It may be that the long-established habit of eating certain quantities of food has a more profound influence upon the appetite than does the intervention of lessened physiological needs. Most of us know the pain that must be endured when the old path is abandoned.

Others grow fat because life has become more difficult for them, not less so. They are persons who are struggling with a problem—sexual, social, or financial—for which they can find no solution. But they have discovered that they obtain temporary solace in eating. For them food acts as a balm as alcohol does for others who find life too hard. We have seen many obese patients who either deliberately or without being aware of the situation have turned to food as a means of relieving pent-up *emotions*. . . .

Obesity is caused by overeating. *Why does anyone overeat?* There are many reasons: (1) because the habit has been inculcated by the overzealous or misguided mother; (2) because great gratification is obtained from the flavors of foods; (3) because the full stomach produces a feeling of repose and comfort; (4) because some people who are struggling with difficulties which they cannot master, obtain temporary respite by indulging in food; (5) because persons whose need for food is lessened by disabling illness or by the advent of an endocrine disease that lowers the metabolic rate, may not experience a shrinkage of the appetite that corresponds with the smaller need; (6) because the requirement of food is greater in youth than it is in later years, but the food habits of the earlier years may still hold sway in middle age.

Dr. Newburgh especially decries the use of thyroid in the treatment of obesity. He feels that the weight of most of these patients is normal and that it is definitely unwise to add the irritability and nervousness of hyperthyroidism to the burden of a circulation already overloaded. He is convinced that it is easier to control weight by lessening food intake rather than through exercise and that emotions use up more energy than thinking does. He advises slower eating.

Dr. Newburgh takes issue with the popular conception that as age increases, so does one's weight. He believes that the size of the bony skeleton has not sufficient influence upon weight to make any significant difference. He does allow some difference for sex. The ideal weight of an individual is the average weight at age thirty. For later years subtract 10 per cent from the ideal weight.

Dr. Newburgh refers to Dublin who analyzed the influence of weight on the duration of life of 192,304 men who were twenty-one years or over when accepted for life insurance. The deaths per 100,000 were as follows:

WEIGHT	DEATHS
Standard	844
Underweights—Total	848
Overweights—Total	1111

He concludes that "the penalty of overweight is one-fourth to three-fourths excess in mortality." Excessive weight carries a much greater risk in persons beyond age forty-five. Twenty-five pounds of extra weight may lessen one's life expectancy by 25 per cent.

Dr. Newburgh also gave a very interesting lecture on basic dietary needs.

He pointed out how diets of the armed forces should be adjusted to their needs as related to the climate they are in.

In our zeal to give nothing but the best to our fighting men we strive to give them animal protein three times a day. This releases too much heat for warm climates, hence it would be best to feed the men in those climates on larger amounts of carbohydrate as a source of energy. Nevertheless it is important to supply essential amino acids. Gelatin is a poor source of protein. The total protein requirement is quite small. Soy beans and wheat apparently contain essential proteins. Rye is next to wheat in protein value. Cheese is a good source of protein, also of calcium.

Dr. Newburgh stressed especially the importance of the vitamins niacin, ribo-flavin, and thiamin. Psychoneurotics usually need thiamin. Ribo-flavin deficiency is responsible for cracks at corners of the mouth. Vitamin deficiency is rarely single, nearly always multiple.

Water and salt are war-time problems for men in our armed forces. In Africa where water is scarce the men lose large quantities, by excretion and therefore the British Army found it most advisable to maneuver at night. For shipwrecked men it is better to supply water than food.

During the luncheon period on Tuesday Dr. Philip Jay gave an informal progress report on Dental Caries Research and answered questions related to the subject.

Tuesday afternoon the subject of "Blood Chemistry" was presented by Dr. Howard B. Lewis.

FUNCTIONS OF THE BLOOD

1. To maintain the fluid balance of the body.
2. To transport nutrients from the alimentary canal—products of digestion.
3. To transport products of metabolism and waste products to be excreted especially by the kidneys.
4. To maintain gas exchange; that is, carbon dioxide and oxygen.

PHYSICAL FACTS ABOUT THE BLOOD

1. The velocity of circulation of the blood is about twenty-two seconds or about three times a minute.
2. The volume of the blood is about one-eleventh to one-twelfth of total body weight, roughly speaking. In an average adult this would be about six liters or 6000cc.
3. The specific gravity of whole blood is 1.060, of erythrocytes, 1.090, of plasma 1.026.
4. The cellular or formed elements are 40 to 45 per cent by volume. The average erythrocyte count in an adult is five million per cu. mm. of blood; the leucocytes number 5,000 to 10,000 per cu. mm., and the thrombocytes number 250,000 to 400,000 per cu. mm. (The blood platelets are markedly increased in Hodgkin's disease and in myeloid leukemia and markedly decreased in hemorrhagic purpura.)

BLOOD PLASMA

1. The water content is 90 to 92 per cent; erythrocytes 64 to 65 per cent.
2. The total protein concentration is 6.5-8.5g. per 100cc.
3. Fibrinogen is 0.2-0.4g. per 100cc.
4. Serum proteins
   a. serum albumin 4.5g. per 100cc.
   b. serum globulin 2.79g. per 100cc.

Fibrinogen is important in coagulation and formation of clot. Its production is controlled by the liver. The body is without any great reserve.

The plasma proteins exert an osmotic pressure of 28mm. The osmotic pressure exerted by a substance depends on the number of molecules in the solution; as albumin has a much smaller molecule than globulin, a given weight of albumin contains many

more molecules than the same weight of globulin, and therefore exerts a higher osmotic pressure. With the normal albumin globulin ratio of 1.53 it is clear that by far the greater part of the plasma osmotic pressure is due to albumin. By virtue of their osmotic pressure the plasma proteins tend to retain fluid in the capillaries and so help maintain the plasma volume, regulate the interchanges between the blood and the tissue spaces and influence filtration in the glomeruli of the kidney. If a marked decrease in plasma protein concentration occurs, oedema develops. This type of oedema occurred in children during the last war, due to poor nutrition. "War oedema" affected 70 to 80 per cent of the children in some European countries. In China, refugees had the same thing.

Several men seem to be on the way to solving the problem of the loss of blood proteins by injecting animal serum proteins or other proteins into the blood stream.

Legumes not too good a source of protein. Yeast protein is a good protein. Alfalfa is an excellent source as is also the edible soy bean—(Soak new dry soy beans 48 hours or more, in this way sprouting them, then cook beans *and* sprouts.) Grass proteins are good. These facts were mentioned by Dr. Lewis because in his opinion there is going to be a shortage of animal and other proteins, everywhere, because of the war.

The blood is also a transfer medium of waste products *from* the tissues and carries a number of other materials which are listed as follows:

	NORMAL RANGE mg.	SIGNIFICANT PATHOLOGIC VALUE mg.	PATHOLOGIC RANGE mg.
Non-protein nitrogen (mostly urea)	25–35	+35	20–400
Urea nitrogen	12–15	+20	5–350
Uric Acid	1–3.5	+4	to 27
Creatinine	1–2	+3.5	to 34
Sugar	70–120	+150	40 to 1300
Calcium (quite stable)	9–11	8—	3–20
Inorganic phosphorus	2.5–4 (adult)	——	2–40
	4–6 (children)	4—	——
Chlorides (Na Cl) whole blood	450–520	500	500—850
CO_2 capacity vol. per cent	50–70	—45	
		+70	

Calcium exists as ordinary inorganic calcium, perhaps as a phosphate and as a non-dialyzable calcium (not bound). Some say it is necessary for blood coagulation, others claim it is not. The anti-hemorrhagic vitamin is vitamin K.

Coagulation of blood after it is shed occurs owing to the interaction of thrombin with the soluble fibrinogen of the plasma to form an insoluble protein, fibrin.

Thrombin is not found in the circulating blood but when blood is shed it is formed from an inactive precursor, prothrombin in the presence of free calcium ions.

The level of prothrombin in the blood depends on the amount of vitamin K in the diet and the rate of absorption.

Vitamin K is a fat soluble vitamin. It is soluble in bile and is reabsorbed from the intestine. It is best administered with bile.

Dr. Lewis also described the mechanism-producing acidosis and alkalosis.

On Tuesday evening and Wednesday morning Dr. William S. Sadler, psychiatrist, and author of a number of books on mental hygiene and related subjects,* gave lectures in which he attempted to draw a parallel between psychopathic syndromes and warring nations. He was an eloquent speaker and stimulated a desire to know more about mental hygiene. Dr. Sadler believes that the simple deviations from normal mental health are conditions which should be understood and handled by parents, teachers, physicians, and ministers, leaving only the more severe and advanced cases for the psychiatrist. He mentioned as a vindication for this belief, the book, *On Being a Real Person* by Harry Emerson Fosdick and recommended it as desirable reading for anyone interested in the subject.

*Including *The Mind at Mischief* and *The Theory and Practice of Psychiatry*.

The Academy member chosen to address the group this year was Dr. Charles H. M. Williams of Toronto. His lecture Tuesday evening on "The Dentition of the Eskimos of Canada's Eastern Arctic" was illustrated with colored movies, and models. A summary of this lecture was published in the *Journal of Periodontology*, 14 (1):34. Jan. 1943. It is to be hoped that all members of the Academy will have an opportunity to see these movies at some annual meeting.

On Wednesday forenoon, Dr. A. C. Curtis showed three cases in the University Hospital. The first was a case of aleukemic leukemia in a man aged 38. The onset of the disease was in February. The patient had a remission and the present onset began about one month previously. He had large red areas on his face and neck which were subcutaneous hemorrhages. Patches were also present under his nails and on his palate. He had a diarrhoea with bloody stool. He was bleeding from the nose constantly. The gingivae were hemorrhagic but not necrotic. The prognosis was poor.

The second case was a lupus erythematosus. This disease may be tuberculous in origin but in this case was not. In this patient the areas were discoid in type and sub-acute. There was marked sensitivity to ultra-violet light.

The third case was a young negro girl with secondary syphilis. Characteristic lesions were noticeable on the palms of her hands. She was non-infectious when seen because she was receiving the so-called "five day cure."

This feature of the course is one of the most popular as methods of diagnosis are given in the most practical manner and no detail is slighted.

On Wednesday afternoon Dr. Cyrus C. Sturgis presented an extremely interesting lecture on "The Anemias."

All patients entering the University of Michigan Hospital now have as routine examinations—a Kahn test, a microfilm of the chest, measurement of the hemoglobin, and the sedimentation rate of the red blood corpuscles. Thus in a routine examination of 736 patients entering for any reason it was found that 24.3% were anemic. There was a slightly higher rate for females, of 389—25.5%. In males an 84% or higher hemoglobin was considered normal, whereas in women 77% was considered the bottom level of normal. Of the entire group 2% had a Kahn reaction.

Hypochromic anemia-lowered color index.

Hypoferric anemia-iron deficiency anemia, very common. Iron necessary to build up hemoglobin. High iron requirement-growth, pregnancy, and menopause.

CAUSES OF DEFICIENCIES

1. Chronic hemorrhage, as in a. hypermenorrhea, b. gastro-intestinal bleeding, such as occurs in peptic ulcer and carcinoma, c. hemorrhoids.
2. Dietary lack

   The average diet contains between 10 and 15 mg. of iron in twenty-four hours. Only about one-half of this is utilized. That which is contained in animal protein is the most readily utilized. Vitamin C is essential in addition to iron and also small quantities of copper and thyroxine.
3. Achlorhydria

The ferric state of iron in food requires hydrochloric acid to reduce it to the ferrous. When there is a lack of HCl the iron is not absorbed. In the presence of infection iron is not utilized properly. Spoon shaped nails are caused by achlorhydria and iron deficiency.

THERAPY

Ferrous sulphate (best form in which to give iron), in enteric coated pills—five grains three times daily.

In a study of 158 pregnant women twenty-seven per cent were found deficient in iron; fifteen per cent deficient in their diet and nineteen per cent had a mixed deficiency. Anemias of pregnancy are due usually to a lack of protein. 80 grams is the daily requirement, of which 30 grams should be animal protein. Milk is deficient in iron and vit. C. Iron should be given throughout pregnancy. A mother's anemia will produce an infant without an iron reserve.

PERNICIOUS ANEMIA

The red cells are greatly reduced in number and abnormal in shape. There is atrophy of the papillae of the tongue.

The cause is apparently due to a lack of an intrinsic factor (still unknown) in gastric juice, acting upon an extrinsic factor in food.

The interaction of the intrinsic and extrinsic factors liberates the hematinic principle which is absorbed and stored mainly in the liver—thus explaining the therapeutic value of liver extracts.

It is thought that pernicious anemia is an hereditary disease and that all these cases have an achlorhydria from birth.

In pernicious anemia there are changes in the spinal cord which result in an ataxia. This may be due to an avitaminosis of the

B complex caused by inability to absorb this vitamin.

In monocytic leukemia there is an abnormal increase in the number of monocytes which ordinarily constitute only 5 to 10 per cent of the white blood corpuscles. The blood platelets are diminished in this disease. Drugs have been known to cause it.

At present an effort is being made to cure this disease by the use of irradiated phosphorous.

The social feature was the Dinner on Tuesday evening attended also by a few Academy members who did not take the Lecture Course, and other guests.

Preceding the dinner Dean and Mrs. Russell W. Bunting were at Home to the group.

At the Luncheon on Wednesday, Dr. Harold J. Leonard moved that the postgraduate course be continued at the Kellogg Institute in April, 1944. The motion was seconded by Dr. Roger E. Huntington and discussed most favorably by Dr. James E. Aiguier. The motion was passed and the council has been informed of the wishes of the group.

The American Academy of Periodontology

Organized May, 1914

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1944 Annual Business Meeting,
CHICAGO, FEBRUARY 19th,
Afternoon and Evening Sessions

Report of Nomenclature Committee of the American Dental Association

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THIS report is the first of a series that the Nomenclature Committee proposes to publish. Succeeding reports on various other phases of dental nomenclature will be presented as soon as the material has been assembled and studied. It is hoped that, in due time, the collected reports from this committee will be made available to dental teachers, editors and authors. By this means, the duties of the Nomenclature Committee as outlined in the By-Laws of the American Dental Association—"to direct the development of scientific terminology related to dentistry"—may be fulfilled.

While notable progress has been made in certain aspects of dental literature in this country, dental nomenclature is still found to be in a more or less deplorable state. There appear to be a large number of poorly defined, etymologically hybrid terms currently used in dental literature. To add to the confusion, several different systems of terminology are used in various fields of dentistry.

Certain objectives in dental nomenclature seem to be desirable. If dental nomenclature is to be in keeping with the high classical and scientific esteem to which dentistry aspires, it should be of pure classical origins rather than made up of a collection of hybrid terms. Dental terms should not only be soundly developed etymologically, but should also be accurately defined. All scientific terms should preferably be fully informative and descriptive. On this basis, the use of eponyms (example: Riggs' disease) should be discouraged. An exchange of ideas and thoughts between individuals is possible only by the employment of a language of marked specificity.

It appears desirable also that unity of dental language be attained in this country. Unless this objective is realized, dental education and dental literature will continue to be characterized by confusion of thought and expression. In the realm of dental education, it is highly desirable that students of dentistry in all American schools be taught in a scientific language common to all. To the end that these objectives may be attained, the Nomenclature Committee solicits the profession's support and herewith presents the first of its reports. This report deals with periodontal nomenclature.

I. PERIODONTAL NOMENCLATURE

The last published American Dental Association report on nomenclature, which was presented by the 1937 Nomenclature Committee,[1] lists the following groups of words as synonyms:

(a) pericementum, peridentium, periodontium, peridental membrane.

(b) paradentium, parodontium.

(c) paradentosis, parodontosis, periodontosis.

(d) periclasia, periodontoclasia, parodontoclasia.

All of these terms are in use today and each has its proponents. This diversity of terms is not only aggravating and puzzling to many, but is obviously also a handicap to dental educators, students and authors. The following discussion is presented in an effort to clarify certain confusions.

Terms relating to the teeth are rooted in both Latin and Greek. The Latin word *dens* and the Greek *odous* serve as the keystones of dental nomenclature. To these roots may be added such prefixes and suffixes as are necessary to formulate words that are in themselves informative and descriptive and that can be accurately and logically defined.

The science of periodontology concerns itself basically with the so-called supporting or investing structures of the teeth. Two prefixes are used to designate these tissues: *peri* and *para*, both of Greek origin. The prefix *peri* has enjoyed a longer use in this country. It was the only prefix used in the earlier phases of the American history of periodontology. The terms *periodontia, periodontology* and *periodontist* were originally formulated with no prevailing suggestion of etymologic controversy. The prefix *para* was seemingly popularized by the more recent appearance of numerous contributions to the American dental literature by European authors.

The prefix *peri* is used in medicine and anatomy to designate tissues that surround,

encase or ensheathe, as in the terms *pericardium, periosteum* and *perivascular.* It is used to designate structures which surround or encase at a distance as well as those immediately contiguous.

The prefix *para* has a much wider use. In anatomy, it is used to designate structures that lie nearby or beside, as in the terms *parathyroid* and *parapineal.* In pathology, *para* is used to designate involvement of structures which lie nearby or beside, as *paracolitis* and *paramastitis.* It is also used in pathology to designate diseases that resemble other diseases, such as *dysentery* and *paradysentery, typhoid* and *paratyphoid.* In chemistry, it is used to designate related compounds, such as *formaldehyde* and *paraformaldehyde.* It is also used to connote embryologic relationship, as *parovarium.* It is apparent that the prefix *para* is one of multiple inferences and is, therefore, not so accurately descriptive as the prefix *peri.*

If dental nomenclature is to be pure rather than hybrid in its origin, the Latin root *dens* should not be used with either of the Greek prefixes *peri* and *para.* Rather the Greek root *odont* (from odous) should be employed.

Among the suffixes which may be employed in the construction of terms related to the subject of this report are the following:

itis: suffix of Greek origin indicating inflammation of the part to the name of which it is attached.

osis: suffix of Greek origin indicating disease in a broad general sense; a more limited meaning being degenerative disease (as nephrosis).

clasia: suffix of Greek origin meaning a breaking off, breaking down or destruction (as osteoclasia); used to indicate, in a nonspecific manner, destructive disease without reference to nature or cause.

On the basis of the foregoing analysis, the following terms are recommended as preferable:

1. Periodontium: The investing and supporting tissues surrounding the tooth; namely, the periodontal membrane, the gingiva and the alveolar bone. Synonyms that the Nomenclature Committee recommends be discarded: parodontium, paradentium, peridentium.

2. Periodontal membrane: The fibrous tissue that connects the cementum of the tooth to the surrounding structures. Synonyms; periodontal ligament, pericementum. Synonym that the Nomenclature Committee recommends be discarded: peridental membrane.

3. Gingiva: The fibrous tissue, covered by mucous membrane, that covers the alveolar processes of the jaws and surrounds the necks of the teeth; the gum.

4. Gingival sulcus: The sulcus around a tooth, bounded internally by the surface of the tooth, and externally by the epithelium lining of the free gingiva. Synonym: gingival trough. Synonym that the Nomenclature Committee recommends be discarded: gingival crevice.

5. Alveolar bone: The alveolar processes of the maxillae and mandible.

6. Alveolus, dental: The cavity or socket in the alveolar process in which the root of a tooth is held by the periodontal membrane. (In general anatomic nomenclature, the term is used to designate a cavity, air sac [lung] or acinus of a gland.)

7. Periodontology: The science and study of the periodontium and periodontal diseases.

8. Periodontia: The branch of dentistry that deals with the science and treatment of periodontal diseases. Synonym; periodontics.

9. Periodontist: One who is learned in the science of periodontology and skilled in treatment of periodontal diseases.

10. Periodontitis: Inflammatory disease of the periodontium. The condition may be further defined and described by such adjectives as acute, chronic, simple, ulcerative, purulent, etc. Periodontitis simplex, secondary to gingivitis. Periodontitis complex, secondary to periodontosis. Synonyms that Nomenclature Committee recommends be discarded: parodontitis, peridentitis, paradentitis.

11. Periodontosis: Degenerative disturbance of the periodontium, characterized by degeneration of connective tissue elements of periodontal membrane and bone resorption. Synonyms that the Nomenclature Committee recommends be discarded: parodontosis, paradentosis, peridentosis, diffuse alveolar atrophy.

12. Periodontal atrophy: Atrophy of gingiva, periodontal membrane and alveolar bone. A type of periodontosis.

13. Periodontal traumatism: Injury of periodontium due to excessive occlusal, op-

erative, accidental or orthodontic stress.

14. Periodontoclasia: Term to indicate non-specifically and collectively all destructive and degenerative diseases of the periodontium. Synonyms that the Nomenclature Committee recommends be discarded: pyorrhea alveolaris, Riggs' disease.

15. Gingivitis: Inflammation of the gingiva.

16. Gingival pocket: Pathologic sulcus about a tooth, deeper than the normal gingival sulcus. Synonym: periodontal pocket.

17. Gingival hypertrophy: Increase in size of gingival tissues; gingival hyperplasia.

The foregoing terminology is in accord with that recommended by the American Academy of Periodontology and adopted as official by that body for its transactions. This report is based in great part on the work of the Nomenclature Committee of the American Academy of Periodontology. The last report from that committee[2] has been freely used as source material. Many others, too numerous to mention, have also contributed to this report. The committee's debt and gratitude to these and to the 1942 Nomenclature Committee is acknowledged.

HARRY LYONS, *Chairman.*

REFERENCES

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2. Report of Nomenclature Committee. *J. Periodont.* 12:16-18, January 1941.

BOOK REVIEWS

The Dental Treatment of Maxillo-Facial Injuries. By W. Kelsey Fry, Dental Surgeon to the Royal Air Forces, Consulting Dental Surgeon to the Ministry of Health, Dental Surgeon to the Guy's Hospital, London, England. P. Rue Shepherd, Dental Surgeon, East Grinstead Maxillo-facial Unit. Alan C. McLeod, Dental Surgeon, East Grinstead Maxillo-facial Unit. Gilbert J. Parfitt, Dental Surgeon, East Grinstead Maxillo-facial Unit. Cloth 246 Pages, 333 Drawings, 32 Plates. Blackwell Scientific Publications, Oxford. Printed by Hazell, Watson and Viney, Ltd., London and Aylesbury, August, 1942.

American Edition, Limited to 200 copies, by J. B. Lippincott, Philadelphia and Montreal.

This is the most comprehensive, complete and conservative presentation of the dental treatment of maxillo-facial injuries that it has been my privilege to study.

Several months ago I purchased an English volume. I prize the work dearly and without reservation commend it and congratulate the authors on their work.

Dr. W. Kelsey Fry or some of his coworkers from the East Grinstead Unit could well be brought to this country in order that the Maxillo-facial Units which will be called upon to serve our boys in the Army might profit by their wealth of experience. We owe our men the advantages of such contacts.

The pages devoted to the comprehensive presentation of this most important and timely subject, compiled from the experiences of the co-authors, admittedly collaborating with many others on the British Isles engaged in the treatment of maxillo-facial injuries are only an indication of the writers' knowledge of the subject.

The frank, conservative and clear presentation is evidence that the writers are well equipped, both from knowledge of the literature and wide experience, to present a text of great assistance and value in the treatment of maxillo-facial injuries.

Deviating from the rules logically drawn for reviewing such volumes, I wish to refer the reader to the Foreword and Preface. One cannot but be impressed by the authors' desire to share full credit with all fellow contributors and also to be amazed at the number of individuals involved in compiling the volume.

This book demonstrates what can be accomplished by the close coöperation of men in many fields of endeavor, unselfishly and untiringly devoting themselves to service and science.

Progress and benefits derived from the logical integration of dental and medical science in time of war could be duplicated

in time of peace by the same intelligent coöperation.

Sad to relate, it seems that the dramatics of war days with interests common to all are necessary to drive the isolationist and autonomist from the scene of action and to bury selfishness. Integration of efforts directed to a common goal is then most effective.

The great catastrophe which befell England in the early days of war clearly demonstrated the need for greatly increased professional services well behind the lines and also at the immediate front. The bombing of the Isles left many injured to be cared for. With the prevalence of maxillo-facial cases, the Ministry of Health assigned to Sir Harold Gillies and Dr. W. Kelsey Fry the responsibility for locating and forming maxillo-facial units.

East Grinstead in Sussex, England, was the first unit formed and was chosen for its location with relation to the bombed area. Here also was a hospital with a plastic surgeon who was not only well qualified but appreciative and interested in the activity, Dr. McIndoe by name.

The dentists of England rallied to the support of the activity both financially and professionally. Through the interest of Dr. Robert Le Cron and others we are proud to know that the American Club of England made quite a handsome contribution toward the activity. Attention of the dentists of this country was called to the work and from here went an ambulance which was equipped as a travelling dental laboratory in order that the service might be carried to the injured in whatever section of England they may be wounded. This ambulance was wisely kept distant from the Hut, rather than jeopardize all equipment under one roof. Following the establishment of the Hut, eight additional centers were located.

With the establishment of the centers arose the problem of staffing and training men to operate them. Logically, East Grinstead became the training center for the staffs of the other units.

With the training of these staffs and others who were to treat the maxillo-facial cases for the armed forces, notes and lectures were compiled and case histories grew in number. The success of the work of these men in their activity both as instructors and scientists was outstanding and astounding and their results gained them commendation from many sources.

Wishing to preserve their notes and lectures in a more permanent form and recognizing the value of sharing their experiences and knowledge with Maxillo-facial Units in other lands, friends prevailed upon the authors to publish this volume. The willingness of the authors to hastily put into print the information gained through their experience with only limited time and under most unfavorable conditions is appreciated. It is unusual to find four men of such outstanding ability as co-authors. The assembling of material and the publication of a book of any character during such times and under such adverse conditions is remarkable.

The selection of East Grinstead with Dr. McIndoe and hospital staff sympathetic to the undertaking was both fortunate and wise.

The book is invaluable both as a reference and as a text book. It should readily find a place in your library and, if you are truly interested in the treatment of injuries to the bones of the face, you will not permit this volume to gather dust.

A bibliography is not included but one can readily recognize throughout the text the co-authors' familiarity with the literature, and had time permitted, they would have given full credit to those having previously contributed to the literature on the subject.

Walter M. Morgan.

THE JOURNAL OF PERIODONTOLOGY

GRACE ROGERS SPALDING, D.D.S., F.A.A.P., *Editor*
Birmingham, Michigan

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A new dental journal may seem to be neither necessary nor desirable. There appears before the mind an array of dental journals, unread and frequently unopened, with their similarity of subject matter and rich display of advertisements. Favorites are read promptly and with enthusiasm. But, because our reading hours are limited, we naturally hesitate to interest ourselves in any addition to the above groups. For several years a definite need has been felt by periodontists for an independent medium of expression to stimulate general interest in, and to record the development of, periodontia. The *Journal of Periodontology,* published to meet this need, makes no claim upon a competitive basis in the field of dental journalism, since it is unlike any other dental journal.

Incongruous as it may seem, most dentists fail to give serious attention to periodontal lesions, although of teeth that are extracted approximately half are lost on account of these lesions. We tend to be indifferent to periodontal conditions, or to delegate the responsibility for their treatment to the physician and the dental hygienist, until such time as extraction is indicated. A careful survey of the gap between the dental and medical points of view would disclose that inattention to the periodontium and its requirements is undermining the foundation upon which dentistry depends for its position as a health measure. To improve our perspective of dental service we must hold the environment and the supporting tissues of the teeth in high regard. The prevention and effective treatment of periodontal lesions is an essential part of the correct practice of dentistry. Since no chain is stronger than its weakest link, we must conclude that until we familiarize ourselves with the principles of successful periodontic practice, and accept our responsibilities in this relation, dentistry will be top-heavy and subject to an undertow of criticism. It is unfortunate that periodontia is looked upon as a specialty, when most of the pathologic conditions in the periodontium are preventable by dentists for their patients. All true periodontists hope that the time will soon come when every graduate in dentistry will be at least as ably equipped to combat periodontal disease as to contend with dental caries.

A suggestion for a periodical dealing with periodontia was made by the President of the American Academy of Periodontology in his address in 1928, but no action was taken. In 1929, however, the sudden passing of one of the most beloved members of the Academy, leading spirit in its organization, a past-president and a fellow, called for a suitable tribute to the memory of Doctor Gillette Hayden, great-granddaughter of the pioneer Horace H. Hayden, M.D., D.D.S. The *Journal of Periodontology* is the out-growth of a suggestion by the present executive of the Academy that this memorial tribute be in the nature of a periodical devoted to periodontia and dedicated to her memory. To be a memorial worthy of her character, the *Journal* must be creative, not competitive—"an opener of doors for" the journals that come after it. It must not pave a blind alley in dental journalism; must be free to publish truth; and must typify service—members of the Academy do, without remuneration, much of the work required in its publication.

The *Journal of Periodontology* is published to serve as the professional journal of periodontia; to keep dentists in touch with research in this and related fields; to stimulate greater interest in the supporting tissues of the teeth and their relation to the general health. It contains original papers of scientific interest, the proceedings of the American Academy of Periodontology, and abstracts of current dental literature relating to periodontia. The abstracts alone make the *Journal* a permanent fund of information readily available to teachers, researchers, clinicians, and students. We hope also it will, in the words of Sydney Smith, "make men wise in ten pages who have no appetite for a hundred pages." This year approximately 200 pages of scientific and practical information will be published; and, since "advertisements add nothing to green pastures," there will be none.

All who are actively interested in the welfare of the new journal are deeply appreciative of this opportunity to present their aims to the readers of the *Journal of Dental Research.* May the latter long continue as the ideal in dental journalism.

[This article is reprinted to record on the pages of the *Journal of Periodontology* its purpose and early history. — ED.]

"What Place Has Surgical Procedure in Periodontia?"— Subject for discussion in January, 1944 issue.

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